

New Programs for Recovery in the Community:

Community Recovery Residences in Rural/Village Locations

Clara Martin Center

Howard Center for Human Services

Washington County Mental Health Services

The Consortium

The Clara Martin Center, Howard Center for Human Services, and Washington County Mental Health Services, have joined in their second collaboration to establish two residential programs for persons with mental illness. These agencies first collaborated over ten years ago to develop substance abuse services for persons in Central Vermont. This program, Central Vermont Substance Abuse Services, has now grown to become an independent 501 C 3 corporation with an excellent community service record. The new effort will provide assistance for persons in need of trauma informed, intensive residential supports heretofore not available outside of a hospital setting.

The Consortium will proceed with making operational The Vermont State Hospital Future Planning Advisory Committee plans for a sub-acute level of care. This plan originally was described in the Vermont State Hospital Futures Plan of February 4, 2005 prepared by then Secretary of Human Services Charlie Smith and is available on line at <http://www.ahs.state.vt.us/vshfutures/VSHFuturesReport02042005.pdf> . Subsequent modification of this plan has continued through the work of a specific sub-committee of the Futures Committee. The plan in the remainder of this document is built upon both the original plan and the subsequent changes to it.

For purposes of developing a viable plan for two locations the Consortium has developed two types of program ideas applicable to a community setting in Vermont. The first describes a setting in a small village or town typical of all but the Burlington metropolitan area. This does not preclude the possibility of such a location, nor does the description necessarily have to be greatly altered for application to that location.

The second location described is a rural location, also typical of the state of Vermont. This would be a site that might be in the far reaches of Chittenden County, or most of Washington or Oranges Counties. Other than the locations of the programs, actual operating policies and procedures should be seen as generally applying to both. When this does not occur it will be noted.

Program A - Village location

The location of a CRR in a small town or large village location would likely most benefit residents who were easily mobile, and were interested and prepared to interact with

community life. Location of the facility would be within walking distance of some shopping, and community activities which residents would initially attend with staff, but over time would want to attend alone or with peers.

The facility would have at least 10 bedrooms and be on a quarter to half acre lot within 1 mile of the center of the town. Travel time of no more than 25 minutes to Burlington (FAHC), Montpelier (CVMC), or Randolph (Gifford) would allow for access to routine and urgent medical care, while all of these would be within 1 hour of the current VSH location. The facility would preferably be DA owned, though a reasonable long term lease could be an alternative. It is expected that some renovation if any site would be needed, thus the actual opening date would be dependent on the degree needed.

Program B - Rural location

A rural location for a CRR is seen as an option for persons who are more in need of the therapeutic community model used in a variety of recovery programs. (Rural recovery programs include Spring Lake Ranch in Cuttingsville, VT; Spruce Mountain Inn in Plainfield, VT; and the former Birch House that was located near Littleton, NH.) As well outside of the Burlington area, most of the southern end of the catchment areas of the Consortium agencies is primarily rural. A similar number of bedrooms (10 plus) would be seen as the target. Acreage would be determined however it is expected that the amount of land be at least 10 acres due to larger parcels with rural homes.

The site of the property would be within 15 miles of Barre/Montpelier, Randolph, or Williston via I – 89, and within 5 miles of interstate access. As with the village location travel time of no more than 25 minutes to Burlington (FAHC), Montpelier (CVMC), or Randolph (Gifford) would allow for access to routine and urgent medical care, while all of these would be within 1 hour of the current VSH location. Though this will be a rural location we would aim to locate on a property near a town center (2-3 miles). Due to the rural location there would be unlimited parking and the indoor space would be large to accommodate staff and residents comfortably.

The facility would preferably be DA owned, though a reasonable long term lease could be an alternative. It is expected that some renovation if any site would be needed, thus the actual opening date would be dependent on the degree needed.

Consortium CRR's

Each of the programs will function similarly to the previous versions put forth by CSAC, HCHS and NKHS. Thus programs will be well integrated with current recovery, trauma informed care, supported employment, co-occurring and wellness initiatives by DA's. As well we encourage integration of former and current VSH staff into the facilities as they might be interested both from the standpoint of consistent care for residents and keeping intact what relationships may exist.

Program specific components are as follows

Staff

In both locations a Recovery-based philosophy—consumer defined goals and objectives reflected in treatment plans and in day to day interactions—will be the general orientation. Staffing patterns will be adequate for individualized consumer care with a goal of 1 staff per 2 consumers (1:2 ratios) to allow for occupational, community, and activity time with staff as needed. Staff will be trained in:

- Trauma sensitive care provision
- Medication management
- Motivational interviewing and methods, and
- Crisis intervention methods to utilize conflict management techniques focusing on non-physical interventions. (This is likely to be NAPPI training.)

Staffing will be maintained at numbers to allow for any level of intervention necessary—4-5 staff available at anytime would be minimum.

There will be an active recruitment of consumers to be on staff at the facility. These persons will be recruited both through agencies and through Vermont Psychiatric Survivors. Roles would include support, advocacy, transportation, home maintenance, home care---and are integrative to the functioning of the program.

All staff will be provided recovery education, using the Mary Ellen Copeland model. Wellness Recovery Action Plans will be developed for each resident with both group and individual tutoring. The eventual outcome will be that at least one staff will serve as an in-house Recovery educator. Staff will endeavor to offer encouragement to all residents

to function at their highest level possible and with a goal of the most independent lifestyle that can currently obtain.

Program Components - Facilities

In both the village and rural facilities a Level III licensing will be sought. Thus all facilities will be operated in accordance with these standards. Though this is an effort by a new collaborative group of DA's, existing DA residential practice patterns—familiar to each of the DA's will be used. Consumers will preferably have private rooms, though there could be some in doubled rooms depending on preference and possible peer support via roommates.

Both of the Community Recovery Residences will have mixtures of private space and communal space. There will be dining areas for main meals, with smaller clustered seating as preferred. Some activity areas will be in facility, but this will be limited to encourage those in the home to attend local events/activities in their town. Outdoor space will have usable areas for contemplation and recreation and in the rural location allow for some therapeutic use of the acreage.

The main entrance to both facilities will be open from 7 a.m. until 9 p.m. every day. Other doors will be electronically locked and with alarms that will sound if opened. This is to ensure that any persons with cognitive/memory issues or legal restrictions on unaccompanied time outside of the facility will be monitored. The main entrance/exit will be locked at 10 p.m. Facilities will be cleaned regularly throughout the day, with consumer help as possible—this is everyone's space

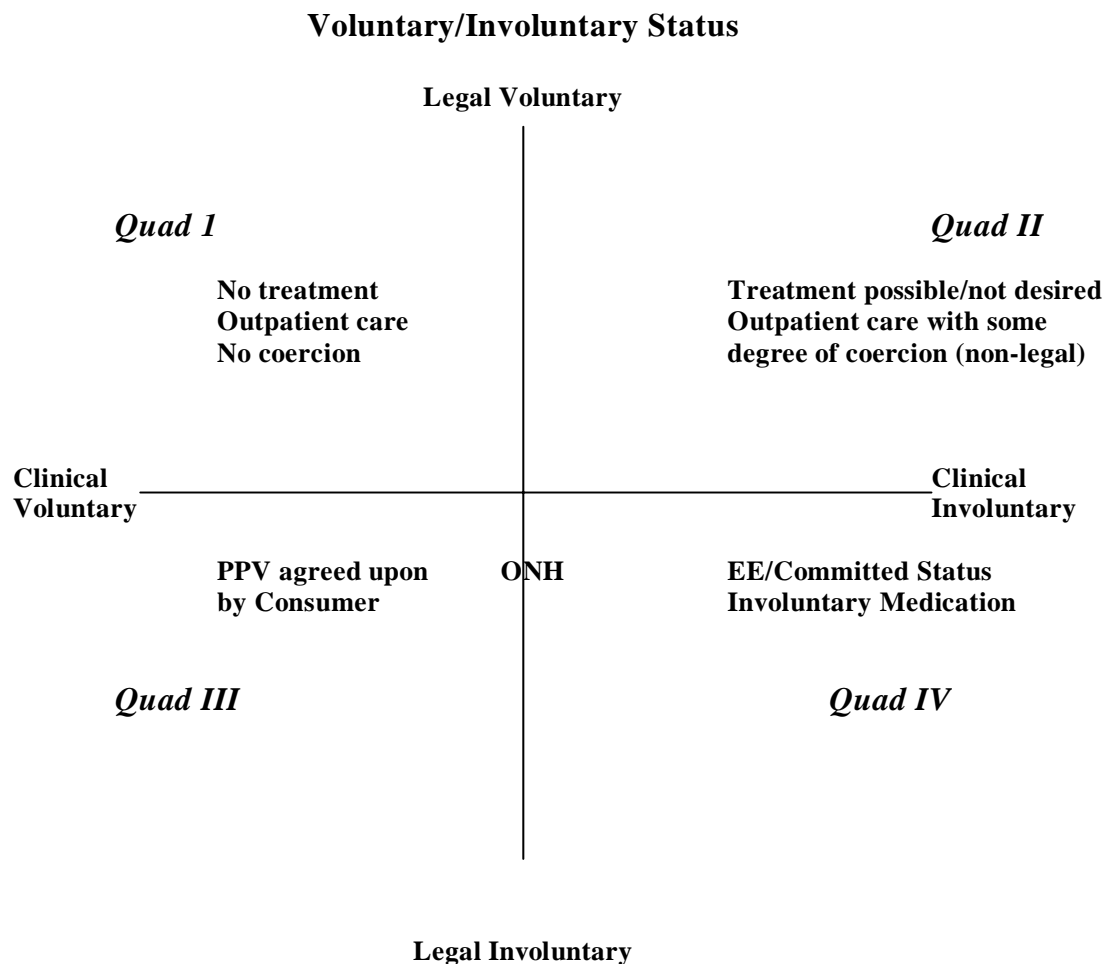
Program Components – Community Supports and Visitation

Each CRR facility will be open for visitation during daytime hours and into the evening up to 8:00 or so, with flexibility as needed. Guests who wish to visit will be welcome on invitation basis. Family, community and support persons will be strongly supported and encouraged to visit. Residents may invite guests to activities at the residence and to share meals. From the outset of our programming efforts we hope to integrate and compliment existing community programs into CRR's—Sunrise Recovery Center, Co-Occurring Disorders services, vocational services all within a trauma informed framework. As well

we will work with local communities to explore what new opportunities will be available from each location.

Program Components – Legal and Clinical

The legal status of persons in residence at the CRR's is likely to be variable. The work of the Futures sub committee on CRR's has established a matrix to best capture the most discernable aspects of legal status. In the diagram below the matrix shows Quadrants I (legally voluntary/clinically voluntary), II (legally voluntary/clinically involuntary), III (legally involuntary/clinically voluntary), and IV (legally involuntary/clinically involuntary) to illustrate the continuum of Legal Status (voluntary to involuntary) and the continuum of Clinical Choice status which attempts to capture the willingness of a consumer to collaborate with treatment.



■**In I** there would be no coercion, and a consumer might have not need for treatment or want treatment with no coercion present in the decision;

■**In II** there might be pressure by clinical care providers, family/support persons, and others for some form of treatment or intervention, but with some degree of coercion though the legal status would remain voluntary;

■**In III** there would be some legal coercion for treatment i.e. an ONH (Order of Non-Hospitalization), a PPV (Pre-Placement Visit), or a condition via the courts or Department of Corrections. In this quadrant the consumer would be accepting and collaborative with the advised treatment;

■**In IV** there would be both legal involuntary status such as EE (Emergency Exam or Warrant status) or Order of Hospitalization, which sometimes may include an order of involuntary medication as well, thus virtually eliminating clinical choice for care.

The CRR's would accept all VSH referrals who meet criteria for placement at CRR in quadrants I(legally voluntary/clinically voluntary), II(legally voluntary/clinically involuntary),and III (legally involuntary/clinically voluntary). Acceptance of persons in Quad IV (legally involuntary/clinically involuntary) is not clear at present.

CRR in the Future

The longer term operation of the CRR programming has yet to be clearly defined by the Futures Committee. Nearly all discussion on this point has had a focus on a next step use of these facilities by DA's, and Designated Hospitals (DH's). These discussions have been clear that both could be utilizing such a placement, however, the immediate needs of patients at VSH are the priority. The hope is from there the general hospital psychiatric units would have access to CRR's as soon as possible. Further along in the process there may also be DA consumers who would benefit from such a facility. Overall there is an expectation that these programs would operate as they are now designed for some time to come.

If you have a need for further information or have questions please contact Michael Hartman at WCMHS 223-6328